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UNEMPLOYMENT RELIEF PROGRAM IN DELAWARE

After conferences between the officers of the Medical Society of Delaware and the State of Delaware Temporary Emergency Relief Commission, which commission also functions in disbursing the funds allocated to Delaware under the Federal Emergency Relief Administration, an agreement has been effected, covering the entire state, which increases substantially the schedule of fees paid the physicians. The commission, which has the final authority in all matters in dispute, did not see fit to grant all our requests, reasonable though we considered them, and even now the schedule is approximately only one-half of that accorded our confreres in Pennsylvania, and somewhat less than the New Jersey schedule. However, when the present fees are compared with the former ones it is apparent that the position of the profession is materially improved, so far as the particular group of patients under consideration is concerned for the schedule is applicable only to those "on the Relief."

The general scheme of the plan is embodied in F. E. R. A. Bulletin No. 7, which we reprint below.

Rules and Regulations Governing Medical Care Provided in the Home to Recipients of Unemployment Relief

The Federal Emergency Relief Administration, Washington, D. C., makes available the following statement as a guide to its personnel and to the public:

The following regulations, governing the provision in the home of medical care (includes "medicine, medical supplies and/or medical attendance") to persons eligible for unemployment relief, are hereby established.

1. *Policy.*—A uniform policy with regard to the provision of medical, nursing, and dental care for indigent persons in their homes shall be made the basis of an agreement between the relief administration and the organized medical, nursing, and dental professions, state and/or local. The essence of such a policy should be:

(*a*) An agreement by the relief administration to recognize within legal and economic limitations the traditional family and family-physician relationship in the authorization of medical care for indigent persons in their homes; the traditional physician-nurse relationship in the authorization of bedside nursing care; the traditional dentist-patient relationship in the authorization of emergency dental care; and

(*b*) An agreement by the physician, nurse (or nursing organization) and dentist to furnish the same type of service to an indigent person as would be rendered to a private patient, but that such authorized service shall be a minimum consistent with good professional judgment and shall be charged for at an agreed rate which makes due allowance for the conservation of relief funds.

The common aim should be the provision of good medical service at a low cost—to the mutual benefit of indigent patient, physician, nurse, dentist and taxpayer.

The policy adopted shall be to augment and render more adequate facilities already existing in the community for the provision of medical care by the medical, nursing and dental professions to indigent persons. It shall imply continuance in the use of hospitals, clinics and medical, dental and nursing services already established in the community and paid for, in whole or in part, from local and/or state funds in accordance with local statutes or charter provisions. Federal emergency relief funds shall not be used in lieu of local and/or state funds to pay for these established services.

The phrase "in their homes" shall be interpreted to include office service for ambulatory patients, with the understanding that such office service shall not supplant the services of clinics already provided in the community.

2. *Procedure.*—A uniform procedure for authorization of medical, nursing, and dental care

in the home shall be established by each state and/or local emergency relief administration. This procedure shall not be in conflict with the following requirements:

(*a*) *Written Order*—All authorizations for medical, nursing and dental care shall be issued in writing by the local relief officer, on the regular relief order blank, prior to giving such care; except that telephone authorization shall immediately be followed by such a written order; and provided that authorizations for bedside nursing care shall be based on a recommendation by the attending physician, in cases where a physician is in attendance, who shall certify to the need for nursing service as part of the medical care. Authorizations for medicine and medical supplies shall also be issued in writing and, in general such authorization shall not be issued except on written request of the physician authorized to attend the person for whose use they are desired.

(*b*) *Acute Illness.*—Authorizations for medical care for acute illness shall be limited to a definite period and a maximum expenditure or number of visits (i. e., not more than two weeks or ten visits), according to the standard agreement made between relief officials and physicians under regulation 1. Medical care in excess of this period shall not be authorized until after a reinvestigation of the case in the home by the local emergency relief administration.

(*c*) *Chronic Illness.*—Medical care for prolonged illnesses, such as chronic asthma, chronic heart disease, chronic rheumatism, diabetes, etc., shall be authorized on an individual basis, and, in general, visits shall be limited in frequency (i. e., not more than one visit per week for a period not exceeding two or three months) by agreement. Nursing care for such chronic illnesses shall, in general, be authorized in accordance with the need for such care as indicated by the attending physician. If necessary, more frequent visits, by the physician or nurse, for an acute attack occurring in the course of a chronic illness, may be authorized. Care for chronic illness authorized under this section shall supplement and not supersede existing community services, such as visiting nursing service or institutional care.

(*d*) *Obstetric Care.*—Authorization for obstetric service in the home shall include an agreed minimum number of prenatal visits (where possible), delivery in the home, and necessary postnatal care. Due caution shall be exercised that this authorization for delivery in the home does not involve undue risk to the patient for whom hospital care may be imperative. The physician authorized to attend the confinement in the home shall be responsible for certifying to the local relief administration that, in his professional judgment, delivery in the home will be safe.

(*e*) *Special Services.*—Medical and nursing services not covered above shall be authorized on an individual basis, subject to the general provisions of the agreement made under regulation 1. Special dental service shall be subject to a similar procedure.

Medical care shall not ordinarily be authorized by relief administrations for conditions that do not cause acute suffering, interfere with earning capacity, endanger life, or threaten some permanent new handicap that is preventable when medical care is sought.

(*f*) *Accessory Services.*—Emergency dental care and bedside nursing service, for indigent persons in their homes, may be authorized subject to the existing general policy of the state and/or local relief administration.

(1) Dental care shall, in general, be restricted to emergency extractions and repairs. Dentists and dental care shall be subject to the same general restrictions indicated for physicians under regulation 1.

(2) Bedside nursing care, where authorized, shall conform to a procedure comparable to the one outlined for physicians above, and shall be provided under an agreement made between relief administrations and nursing organizations, state and/or local, under the same principles suggested for physicians under regulation 1. Standards of accredited local nursing organizations shall be followed by nurses giving authorized bedside nursing care to indigent persons in their homes. Such authorized bedside nursing care shall not supersede or supplant existing local official services giving such care under the provisions of local law.

(*g*) *Fee Schedule.*—The agreement between the state and/or local relief administration and the organized professional groups of physicians, nurses and dentists, state and/or local, established under regulation 1, shall include a fee schedule covering the basic and special services

outlined in sections (*b*) to (*f*), inclusive, of this regulation. In the interests of simplified accounting it is suggested: That a flat rate be established, on a per visit basis for the usual care given to acute and chronic illness (sections (*b*) and (*c*) above), for attendance at confinement (section (*d*) above), for emergency extractions (section (*f*) above), and for a bedside nursing visit (section (*f*) above); and that all special services (medical, nursing or dental) be covered by an agreed reduction from the usual minimum fee schedule for such services with an agreed maximum fee. A recognized differential in fee shall be established between a home and an office visit. All fees shall be established on the basis of an appreciable reduction from the prevailing minimum charges for similar services in the state and local communities with due recognition of the certainty; simplicity and promptness of payment that authorization from the local relief administration insures. This schedule shall only apply where the expenditure of federal relief funds is involved and shall not preclude the payment of additional amounts from local funds.

Where bedside nursing care is authorized, the flat rate per visit shall be established by agreement at not to exceed the certified cost per visit established for accredited visiting nursing organizations in the state or local district.

(*h*) *Bills.*—Physicians, nurses (or nursing organizations) and dentists who are providing authorized medical care to indigent persons in their homes shall submit to the local relief official, monthly (within ten days after the last day of the calendar month in which such medical care was provided), an itemized bill for each patient. Each bill shall be chronologically arranged and shall contain at least enough information to permit proper audit (i. e., name, age and address of patient; general nature of illness or diagnosis; whether home or office treatment; dates of service; and status of case at end of month—cured, sent to hospital, dead, needs further care, etc.) Bills for medical care shall be accompanied by the original written order for such care, except for cases in which medical service under an authorization has not terminated during the calendar month covered by the bill, in which cases the bill shall show, in addition to the details required above, the date and serial number of the outstanding order. Retroactive authorizations shall not be issued or honored for payment.

Bills for special and accessory services, outlined under sections (*e*) and (*f*) above, shall give full details of such services, and bills for medicines and medical supplies, under (*i*) below, shall be subject to the same general requirements. Bills for drugs shall list the name and quantity of each. The formula and number of each prescription costing more than 25 cents shall be submitted with or made a part of the pharmacist's bill.

NOTE—The submission of bills and their audit and authorization for payment will be simplified if the state emergency relief administration provides a suitable bill form.

(*i*) *Medicine and Medical Supplies.*—Physicians providing authorized medical care to indigent persons shall use a formulary which excludes expensive drugs where less expensive drugs can be used with the same therapeutic effect. When expensive medication is considered essential by the authorized attending physician, it may be authorized after consultation with the local medical advisory committee.

Prescriptions for necessary drugs and medicine shall be restricted to the National Formulary or the United States Pharmacopeia. To avoid excessive expenditures for remedies of unknown or doubtful value, proprietary or patent medicines shall not be authorized.

State and/or local relief officials are urged to make trade agreements with pharmaceutical organizations and druggists for uniform or reduced rates for prescriptions.

Authorizations for medical supplies shall be restricted to the simplest emergency needs of the patient consistent with good medical care.

In general, authorizations for medicine and medical supplies shall not be issued except on written request of the physician authorized to attend the person for whose use they are desired.

3. *Authority.*—The state emergency relief administration, responsible for the distribution of federal and state emergency relief funds to local relief administrations, shall give approval to such statements of policy, proposed fee schedules, and detailed procedures, governing the provision of medical, nursing and dental care in the home to recipients of unemployment relief, as may be established by state and/or local relief administrations, in accordance with the provisions of

regulations 1 and 2, above, before such policies, schedules and procedures shall take effect. It shall be the responsibility of the state emergency relief administration to formulate a program of medical, nursing and dental care for indigent persons in their homes, which shall not be in conflict with the provisions of regulations 1 and 2, above, and to make sure, by giving or withholding approval, that analogous programs formulated by local relief administrations shall not be in conflict with such state program.

(*a*) *State and Local Professional Advisory Committees.*—State and local relief administrations shall request the presidents of the state and local medical, nursing, dental and pharmaceutical organizations, respectively, to designate an existing committee or appoint a special committee, to advise them in the formulation and adoption of adequate programs for medical, nursing and dental care in the home for indigent persons. The relief administrations shall be responsible for the final adoption of such programs. The medical, nursing, dental and pharmaceutical advisory committees can assist these administrations in maintaining proper professional standards and in enlisting the cooperation of the constituent, professional membership in such programs. Local medical, nursing and dental programs submitted to the state relief administration for approval should be submitted to the appropriate professional advisory committee for comment, before final approval is given. The appropriate professional advisory committees should be consulted by relief administrations with regard to disputed problems of medical, nursing and dental policy and practice.

(*b*) *Licensed Practitioners of Medicine and Related Professions.*—When a program of medical care in the home for indigent persons has been officially adopted, participation shall be open to all physicians licensed to practice medicine in the state, subject to local statutory limitations and the general policy outlined in regulation 1, above. Physicians authorized by relief officials to give medical care under this program shall have accepted, or shall be willing to accept, the regulations and restrictions inherent in such a program. In order to provide adequate medical care it may be desirable for local relief officials to maintain on a district basis a list or file of physicians in the community who have agreed in writing to comply with the officially adopted program. Such a list of physicians should also facilitate a more equitable distribution of orders for medical services.

A similar policy and procedure shall be followed in the preparation of approved lists of nurses, dentists and pharmacists. Licensure and/or registration to practice their respective professions in the state shall be a prerequisite to approval of graduate nurses, dentists and pharmacists for authorized participation in the officially approved state program for the provision of medical care for indigent persons in their homes.

(*c*) *State Program for Medical Care to Indigent Persons in Their Homes.*—When the state emergency relief administration has adopted a uniform program for medical, nursing and dental care for indigent persons in their homes, in accordance with these rules, a copy of such program, including the statement of policy, fee schedules and detailed procedures, shall be filed immediately with the Federal Emergency Relief Administration.

The Act of Congress which appropriated $500,000,000 for this relief also makes plain that absolute honesty is required of the physician. Any physician who pads his accounts or otherwise wilfully demands payment not earned is liable to a fine of $10,000, a sentence of five years, or both, in the discretion of the court. Such sharp teeth, we are sure, will never be needed in administering this law in Delaware.

In accordance with the above general plan, the specific regulations and schedule applicable to the State of Delaware are as follows:

Rules and Regulations Governing Medical Care Provided to Clients of the Delaware Temporary Emergency Relief Commission

Effective December 5, 1933

The regulations listed below cover the policy of the Delaware Temporary Emergency Relief Commission, with respect to medical care, and supersede all previous instructions issued previous to the above date.

All such medical service shall not supplant the services of clinics already provided in the State, but positively implies a continuance in the use of hospitals, clinics, and medical services already established in the various communities.

and paid for in whole or part from local or State funds.

1. The fee charged for the initial home visit of a physician shall be One Dollar and Fifty Cents ($1.50). The initial visit of a physician shall be construed to mean the first visit made on any one spell of sickness. Two initial charges cannot be made on the same sickness of any one patient.

2. The fee charged for each subsequent home visit shall be One Dollar ($1.00).

3. The fee charged for each office visit shall be Fifty Cents ($.50).

4. In case of pregnancy and miscarriage, the patient should be sent to a hospital. When, in the physician's judgment, such hospital treatment is precluded by the patient's condition, or cannot be obtained due to some other circumstance (i. e., no hospital accommodation available), such cases shall be treated in the home. The fee charged for these home treatments shall not exceed Fifteen Dollars ($15.00), which shall include all pre and post natal visits.

5. Physicians shall be reimbursed for all medicines and materials used in connection with the visits specified in Paragraphs One, Two, Three, and Four. The charge for such medicines and materials shall be computed at cost to the doctor.

6. Physicians shall be compensated for traveling expenses for cases in rural districts only and incurred where the physician is obliged to travel more than two miles from his office to make the call. Such compensation will be at the rate of Fifteen Cents ($.15) per mile and will be allowed only for each mile over two miles traveled during each visit.

7. Where more than one person is treated in a family at the same time no extra charge will be made except for the actual cost of bandages or medical supplies used.

8. No physician shall render a bill for medical care to a client of the Temporary Emergency Relief Commission unless authorized to do so by the visitor responsible for that client, or if the visitor cannot be reached, by the visitor's supervisor. Such authorization can be given over the telephone but must be followed promptly by written confirmation from the case worker to the physician. When such written confirmation is not forthcoming within 48 hours, it shall be incumbent upon the physician to contact the worker or supervisor to obtain same.

9. Authorizations for medical care for acute illness shall be limited to a definite period and a maximum expenditure or number of visits (i. e., not more than two weeks or ten visits). Medical care in excess of this period shall not be given by the physician unless authorized by the case worker or the case worker's supervisor.

10. The prior authorization rule may be waived by the physician on Saturday afternoons, Sundays, and holidays, also evenings in emergency when visitors are not on duty (5 P. M. to 9 A. M.), and he may furnish whatever medical care he deems necessary. However, he must notify the case worker or the case worker's supervisor the following work day.

11. Each bill must be submitted to the Commission on or before the 15th of the following month by the physician covering visits made during the preceding month; the bill must be in duplicate and contain an itemized list of the patients visited, their addresses, date of each visit and kind of visits, accompanied by a diagnosis, which shall be confidential. This information is necessary to expedite payment, and any bill lacking such data will not be honored.

12. Emergency medical services, including operations and X-rays, shall be authorized on an individual basis, subject to the general provisions of this policy.

13. The State and County Committees on Medical Economics will act in an advisory capacity in problems mutually affecting the relief administration and the medical profession.

14. The traditional family and family-physician relationship shall always be recognized, and in the event no such family-physician exists, the patient shall exercise free choice of physician.

There are three general operating districts for relief operations in this State by Counties. Joint relief directors for New Castle County, are Mrs. Helen W. Gawthrop and W. D. Smith, address, M-217, Delaware Trust Building; Kent County, Mrs. James H. Hughes, "The Green," Dover, Delaware; and for Sussex County, Mr. J. Wiley Trought, Laurel, Delaware.

Any inquiries concerning details of operations should be directed to the respective regional directors, and bills as well should be sent to these people with the exception of New Castle County.

In this instance bills authorized for cases in the area south of the Delaware-Chesapeake Canal to the Kent County line, should be forwarded to Dr. Louis Levinson, Middletown, Delaware. In the city of New Castle, bills will be authorized and should be forwarded to Mr. Newlin T. Booth. The remainder of the County in the city of Wilmington, bills will be authorized by the Family Relief Unit, 6th and Shipley Streets.

These regulations are self-explanatory and little difficulty in their administration is anticipated. Until they and the routine procedures involved are mastered by both, the profession and the personnel subordinate to the commission it is possible that minor misunderstandings may arise. There will be no difficulty, however, in ironing out any problem that arises, as we can assure the profession that the members of the Commission are citizens of the highest character, who have dealt with us in a sympathetic and understanding manner, and to them we extend our sincere thanks for establishing the new schedule.

Another angle to be borne in mind is contained in the following letter from the Secretary of the American Medical Association.

To the Secretaries of the Constituent State Medical Associations:

Dr. W. C. Woodward, Director of the Bureau of Legal Medicine and Legislation of the American Medical Association, has sent me from Washington a statement concerning the results of conferences held with the Federal Relief Administrator. I shall attempt in this communication to submit to the secretaries of the constituent state medical associations what seems to be the official attitude of the Federal Relief Administrator as it is understood by Dr. Woodward:

In a prolonged conference with Mr. C. M. Bookman, Assistant Administrator of the Federal Relief Administration, Doctor Woodward discussed with him each and every one of the problems stated in letters and telegrams received from secretaries and other officers of state medical associations in reply to a telegram which I addressed to all state secretaries on November 16. All of these problems, Mr. Bookman concluded, were local problems and should be adjusted by the state medical associations and the corresponding state relief administrations.

The several state relief administrations are directed by groups of responsible men and women appointed by the governors of the several states with the approval of the Federal Relief Administration. The Federal Relief Administration has laid down certain principles for their guidance in Rules and Regulations Number 7. These principles were laid down along broad lines so as to leave the several relief administrations throughout the country a wide discretion in organizing state relief in the manner best suited to local conditions. The Federal Emergency Relief Administration is loath, therefore, to undertake through federal agents, to determine the needs of the several states and to direct state relief administrations to adopt measures not approved by the best judgment of the state agency.

That state relief can be organized to the satisfaction of the medical profession in accordance with principles laid down in Rules and Regulations Number 7 is apparent from the fact that it has been done in some states. Where a satisfactory organization has not been effected, the state medical association should get together with the state relief administrators to determine why and to remove obstacles to a successful organization. It is not necessary for any state medical association to wait for a state relief administration to take the initiative. If the state organization is such as to leave sick and injured persons and women in confinement without adequate medical service, concrete evidence of that fact should be submitted to the state relief administration with suggestions for correction. The suggestions should take into consideration, however, not only federal resources but also state resources susceptible of being made available or already available. Only in event of the inability or unwillingness of a state administration to utilize available resources for medical relief with resultant unnecessary suffering will it be worth while to take the matter up with the Federal Relief Administration. Even then, if it is taken up with the Federal Administration, it must be remembered that the State Relief Administration is made up of men and women of standing in their community, selected by the Governor with the approval of the federal authorities, and every presumption will be in favor of the regularity and efficiency of their action.

Men and women taken off relief rolls and

placed on payrolls of the Civil Works Administration will not be entitled to medical relief at public expense. Physicians who attend such employees and their families must look to the head of the family for payment. If, however, such an employee is so situated that the wages he receives are inadequate to pay for medical service for himself and dependents, he may submit his case to the state or local relief administration. If the relief administration determines that the situation of the applicant is such as to warrant the furnishing of medical service at public expense, it will make some arrangement to furnish it. Just how this will be done, whether by placing the applicant on the relief rolls or in some other way, is a matter to be worked out locally. The situation is one that is likely to call for a large amount of free service from the medical profession, for it is unlikely that many persons suddenly taken from relief rolls and placed on the civil works rolls will be able to pay for medical service. This will be true particularly in the case of those transferred workers who are heads of families. If a person is able to provide himself and his family with food, clothing, fuel and shelter but is unable to provide medical service, he may be placed on the relief roll and needed medical service provided at government expense.

It would seem, from the attitude of the Federal Relief Administration as above set out, that in the matter of providing medical service for persons who have been taken off relief rolls and placed on payrolls of the Civil Works Administration the medical profession will simply have to make the best out of the situation that it can. It is to be doubted that the profession can ask that the pay of all workers on the civil works rolls be increased so as to enable them to pay for medical service or that the pay of some of them who need medical service be increased above the pay of others not so situated while both are engaged on the same class of work.

It is important to note that an applicant for relief at government expense must be placed on the relief roll by the Emergency Relief Administration, even though the only relief he seeks is medical relief, and that an order from the relief administration is necessary if the attending physician expects the government to pay for his services.

I am inclined to the opinion that an increasing number of physicians in various parts of the country entertain grave doubt as to the desirability of accepting direct payment for medical services from the government. I gather from statements which have come to me from a comparatively large number of physicians that some feel that the acceptance of compensation from the government in nominal amounts may constitute a precedent whereby it will be made exceedingly difficult to maintain fee schedules heretofore adhered to, if and when there has been distinct improvement in the general economic situation. Many others appear to entertain the fear that the acceptance of compensation at the hands of the government may encourage the development of some system of governmental control of medical practice. However this may be, it is undoubtedly a fact that many physicians in various parts of the country have about come to the end of their own resources, and that it will be difficult for them to carry on unless they can receive some compensation from some source.

We shall be greatly obliged if you will keep us advised as to any further developments in your state with respect to emergency medical relief.

Very sincerely yours,

OLIN WEST

December 7, 1933

THE EARLY RECOGNITION OF CANCER*

THOMAS S. CULLEN, M. D.
Baltimore, Maryland

DR. THOMAS S. CULLEN: It was my good fortune to meet several of the representatives from Delaware in Chicago last Thursday and Friday. My voice was nearly gone, and the question was whether I could speak at all this evening. I wish I had such a voice as your distinguished president and mayor, so it would carry to all parts of the room. If I should stop at any time you will understand it is because my voice is broken.

Now I am going to discuss the cancer campaign very briefly. In the fall of 1912 I was gathering together the results in cases of cancer

*Address delivered before the General Public Meeting of the Medical Society of Delaware, Wilmington, September 26, 1933.

in the neck of the womb that we had had in Baltimore. After following all these cases up I found that 26% of those that had been operated on were well at the end of five years. That was much better than we had been able to do heretofore, but we had apparently reached the limit and nothing further could be done unless we tackled the subject from another angle, and we came to the conclusion that the only way to increase the percentage of recovery was to educate the people as to the early signs of cancer. In that way they might be on the lookout for symptoms of the disease and we could get the cases early at a time when something might be accomplished.

I took the matter up at once with Dr. Franklin H. Martin, editor of *Surgery, Gynecology and Obstetrics*. He advised me to formulate my plans and bring them up at the meeting of the Clinical Congress of Surgeons that was to take place in Brooklyn the following month. I did so and the idea had the backing of the 2400 surgeons who attended this congress. It fell to my lot to be chairman of the committee that was created, and we were instructed to use the daily press and the weekly or monthly magazines, as might be deemed most expedient.

Then the question arose as to how to start with the education on the subject of cancer. When we looked into the matter carefully we found that if a man was sick he did not pay any attention to himself. It was his wife, his daughter, or one of the other female members of the family who urged him to go and see the doctor. So we came to the conclusion that all that was necessary would be to educate the ladies and they in turn would impart the necessary information and use the necessary force to bring the men to the physician at the earliest moment.

I wrote an article—did not sign my name—and took it up to the *Ladies Home Journal*. I can see the managing editor now, smoking a long cigar and scowling all the time that he was reading it. I said, "Isn't it clear enough?" He replied, "Yes, it is too damn clear. Most of our ladies would grab their hats and go to the nearest doctor. We have to get a layman to write that subject up." We independently struck upon Samuel Hopkins Adams who had written "The Health Master." I went in to see Mr. Bok, and he said, "You know I am a Dutchman, and I am very much interested in the subject of cancer. One of my family had it." I said, "Do you know Treub of Amsterdam?" He almost jumped out of his chair and said, "Yes, he operated on one of my family." That was an open sesame from that moment on we could have anything we wanted to disseminate on the subject of cancer carried in the columns of the *Ladies Home Journal*.

I had Samuel Hopkins come to Baltimore and gave him a terrapin dinner at the Maryland Club, where we had about ten or twelve people especially interested in the subject of cancer. From there he went to New Orleans to write up the Mardi Gras and get the subject of cancer for the time being out of his system. Then he went to Chicago, then to the Mayos, and then the article was written. It was carried from the *Ladies Home Journal,* into *McClure's* and *Collier's* and various other magazines, into the daily press of New Orleans, the *Detroit News* and other daily papers, and it was estimated that as the result of the first attempt at publicity we got a reading public of about eleven million.

Shortly after Samuel Hopkins Adams' article came out one medical man met me and said, "Cullen, as a result of that article in the *Ladies Home Journal* I have seen six early cases in the course of a week."

So much for the start. You must realize that starting a publicity campaign was a rather dangerous proposition for the medical profession to undertake, because advertising might have been suspected, and the medical profession had not then taken the public into its confidence as much as it has in later years. However, with the backing of such a distinguished group of men, 2400 surgeons, we had no trouble. Then in the early days we had to be very circumspect in our remarks. We did not call a spade a spade. I remember giving a talk at the American Medical Association in Philadelphia, and I was assigned to a Methodist church there on a Sunday evening. I gave a talk on cancer, and fortunately the minister, who was broad-gauged and could sense what was in the air, took as his lesson the woman with the bloody flux; so after that in speaking of the symptoms all I had to refer to was the lesson of the evening and did not give any of the symptoms.

Now the first question is, what is cancer? It really is a tree-like growth; it grows out and

grows into the depth, but it is like a great many of our investments—mushroom-like and without any stability. The superficial portions of the cancer break down; unfortunately, the deeper portions keep on advancing. With the breaking down there naturally will be some discharge, and every now and then a certain amount of blood associated with it.

Let us briefly take up the kinds of cancer. We have lip cancer, and those of you who are well along in years will remember seeing a great many cases; but I feel sure that my colleague and friend, Dr. Dean Lewis, will agree with me that lip cancers are not so frequent as they used to be. In the old days most of the older members of the audience never had anything to do with clay pipes except to use them for blowing bubbles, but the old smokers would find that the stem of the clay pipe would stick to the lip and every now and again peel off a little skin, and that produced an irritation. In due time some of the smokers would have a cancer develop on the lip. Now we are warned as to the milky patches that develop on the surface of the lip, and these milky patches, if they are allowed to go on, may develop into cancer. But if we go to a physician at once and have them looked after he will suggest the appropriate treatment and these milky patches will disappear.

Then you know of cancer of the tongue. There used to be a number of these cases, and there are some now, but the dentists have come along and told us about the irritations of the mouth. They have taken out the jagged teeth and left the mouth clean, and they deserve a great deal of credit for reducing the number of cancers of the tongue.

We have little growths developing on the face in various places, and the late Dr. Keen, of Philadelphia wrote a wonderfully good paper on moles. Every now and then one of these brown moles may give rise to trouble; not often, but it is wise to have them looked after if they increase in size. I want to tell you a mole story, a story that will always fit in with this subject of moles and the advisability of having these moles looked after.

There was a young lieutenant sent from Brownsville, Texas, to Leavenworth, and he carried with him a letter from his colonel at Brownsville to the colonel at Leavenworth. The letter said: "This will introduce Lieutenant So-and-So. He is a perfectly splendid fellow, but he is an inveterate gambler." The colonel at Leavenworth threw the letter over to the lieutenant, and he started to laugh and said, "It is perfectly true, Colonel, but I can't help it. I will bet you $25.00 that you have a mole on your right shoulder." The colonel replied, "I haven't." "Well," said the lieutenant, "I bet you you have." The colonel said, "All right; I'll show you," and he took off his coat and vest and shirt and there was no mole there and the lieutenant lost the $25.00.

The colonel in writing related this experience to the colonel at Brownsville, and the reply came, "The rascal; he bet me $100.00 that he wouldn't be with you ten minutes before he had your shirt off." (Laughter). Remember this story, then, always in connection with moles and have them removed.

Then we have growths in the breast. My friend, Dr. Lewis, is much more familiar with them than I am. Every lump in the breast needs careful watching. It may be a very simple thing and it may not, but if you find any growth you should go at once to your family physician and he in turn will send you to the surgeon if necessary. It was only last week that I saw a tiny nodule, apparently perfectly innocuous, no danger to it, which, when examined microscopically, was one of the earliest cancers I have ever seen. Whenever there is any lump in the breast, don't take the responsibility yourself; go to the clearing house, that is, your family physician, and have the lump examined. If there is anything suspicious he will look into the matter further and have the growth removed.

Then we have the growths of the stomach and the small intestine, chiefly of the stomach, and they may advance a long way before there are any symptoms. I am reminded of a time I went out berry picking right near an old barn. Everything looked all right, but suddenly smoke came from the roof and within a minute the whole place was ablaze. Sometimes these conditions are far advanced before there are any symptoms whatsoever. Every now and then there will be a patient with a lump in the bowel. Fortunately, a certain number of these cases are recognized because there is a sudden shutdown and the patient has a temporary obstruction that draws attention to the condition.

Farther down we have growths in the rectum. With cancer of the rectum, of course, there is bleeding and also a certain amount of discharge; but with the appropriate instruments one is able to determine the trouble.

Now let me mention bleeding from the womb. It may be a very simple thing or it may be a very serious thing, and many women go on for weeks and months just harboring that symptom, saying nothing about it but worrying greatly. Sometimes the bleeding is caused by a simple condition—a little polyp or something like that —or it may be due to something very serious. If you have a suspicious condition in the neck of the womb, your family physician will send you to a surgeon. He will cut a little piece out and within twenty-four hours the microscopic examination will tell you exactly what is wrong. Then, again, if the trouble be inside the womb, the surgeon will curet out little pieces of tissue and cut little sections of that tissue, a thousandth of an inch thick, and examine them under the microscope. The pattern of the diseased tissue and that of the normal are as different as are two kinds of wall-paper, and one can usually make an absolute diagnosis.

The same thing applies to blood in the urine. It may be from a simple condition and it may be from a serious one, but with the appropriate instruments we can determine the cause and whether the bleeding is due to malignancy.

I have gone over briefly the conditions that we find. What is the treatment? The knife, radium and x-ray, depending on the condition, how far it is advanced and what the surgeon finds best in the individual case.

Let us see for a moment what we do in ordinary business. In the factory there is every now and then a shutdown to see if the machinery is in good shape, and things are overhauled. When a train comes into the terminal everything is examined and parts that are not shipshape are removed or changed, so that when the train starts out again everything will be all right. You take good care of your automobile. You send it to a garage every five hundred or thousand miles to have it fixed up. It is just as necessary that you should have your bodies looked after. If there is any little squeak, anything wrong, you go right to your physician and get an overhauling, and if you do this regularly you won't lose much time if anything be wrong.

You are all familiar with the story of John Quincy Adams walking along the street one morning and staggering. Somebody said, "Good morning, Mr. Adams, how are you?" He replied, "I am feeling very well, but the house I am living in is so dilapidated that I think I will soon have to leave it." The only thing for you to do is to look after your house, your human house, and keep it in just as good order as you would your own home.

Just remember that fifty years ago few if any cases of cancer were cured. Now a great many are cured. There will be still more if you have things looked after early. I am reminded of two friends of mine on the Eastern Shore. One of them I operated on fifteen or eighteen years ago for cancer. She is well. Her husband was operated on for cancer of the bladder when over 70. He is now over eighty and he is well. It is not often that we get 100% permanent cures in one family, but it makes us very happy when we do, and I urge upon you if you have anything wrong, if you have any symptoms that can not be explained, to go to see your family physician at once.

Scientific Exhibit: A. M. A.

Application blanks are now available for space in the Scientific Exhibit at the Cleveland Session of the American Medical Association, June 11 to 15, 1934. The Committee on Scientific Exhibit requires that all applicants fill out the regular application form and requests that this be done as early as convenient. The final date for filing applications is February 26, 1934. Any person desiring an application blank, should address a request to the Director, Scientific Exhibit, American Medical Association, 535 North Dearborn Street, Chicago, Illinois.

Feeding Byrd's Expedition

Dr. Guy O. Shirey, chief medical officer of the Byrd Expedition II which with a crew of thirty-eight men will be tied up in the Antarctic ice over two long winters was selected by Admiral Byrd because of his wide experience and knowledge of how to take care of men—how to keep them fit under almost unbelievably rigorous conditions.

Naturally, one would think that medicines would be Dr. Shirey's main concern, and they

are important, but he believes in the good old adage that "an ounce of prevention is worth a pound of cure." The first thing necessary, and the most vital thing of all, is to keep the men well, and so to build up their resistance that they will be able to resist the most severe cold and undergo the greatest hardships, and stay not only well, but healthy and vigorous.

First of all, this requires good food of the right kind to fulfill every possible requirement. Dr. Shirey believes, with Napoleon, that an army travels on its stomach. But it happens that Dr. Shirey's food problems are much more difficult because they are so complicated. For instance, when a dog sledge journey starts out over the ice, the food supply carried along must furnish the greatest amount of food value and stimulation with the least possible bulk and weight. It may happen that the ice parts behind them and so, the return being cut off, the crew is forced to camp on the ice for an indefinite period awaiting relief, during which time human life may depend upon the rationing of a few precious ounces of food to each man.

Dr. Shirey named the articles in his regulation diets for such expeditions away from their base camp in Little America. You may be surprised that among them are some of the most common everyday foods: biscuit, oatmeal, dried milk, butter, sugar, salt, tea, coffee and cocoa. In addition Dr. Shirey specifies three articles of diet particularly adapted for men undergoing extreme cold and severe hardships. In emergencies, a ration of the following without other diet will maintain and stimulate greatly the vigor of the men:

Pemmican (a concentrated food consisting approximately of 50 percent fat and 50 percent dried meat protein. It was first prepared by the Indian tribes of North America from buffalo meat or venison.)

Erbswurst (a concentrated food composed of pea meal and bacon which originated in Germany.)

Bovril (a highly concentrated beef beverage containing highly concentrated yeast extract, which originated in England, and now coming into use in America as a stimulating hot drink, being prescribed by physicians, and used in the diets of college athletes, etc., for its energy-giving qualities.)

In the selection of supplies for the trail, judgment of the items was based pretty much on what other explorers of the top and bottom of the world have used successfully. Nansen in the Arctic, and Scott and Shackleton in the Antarctic used practically the same list of solid foods, together with the latter named concentrated beef beverage.

Fuel also must be light in weight and, therefore, concentrated. So, for heating food and beverage on the trail, little cubes called "Meta," obtained in Switzerland, will be used as the emergency heat. Its advantages being that it is easily kindled, burns with a smokeless flame and leaves no residue or ash. It is a definite chemical compound formed by the union of ammonia and formaldehyde.

One of the most interesting factors in safeguarding the health of expedition members is the material in a little bottle which Dr. Shirey brought back from an extended trip abroad. There are only two ounces of it and the color is greenish yellow. This is a very recent discovery of science, and it is said that it represents sufficient Vitamin C for the whole party for a couple of years. When you think how many bushels of fresh fruit it would require to supply the members of the expedition with Vitamin C, the reason for taking this newly discovered concentrate along is obvious.

However, vegetables will be taken along but they will not look much like those fresh from the garden because the water content has been removed. A scientific process of dehydration developed by Dr. Paul A. Boncquet, professor of chemistry of food and nutrition at the University of Southern California, not only will preserve the vegetables but also will retain their cellular structure and chemical composition so that when prepared for the table they will be the equivalent of the fresh vegetables in flavor and nutritive qualities.

Not so many years ago the dangers incurred in the Arctic and Antarctic regions by such an expedition meant malnutrition and death to many of its members. Now, mostly through the knowledge of scientific nutrition, sickness is largely prevented and death defeated. In his former expedition to the Antarctic, Byrd did not lose a single man, and no one suffered even serious illness. And in this great adventure, Byrd Antarctic Expedition II, every possible precaution is being taken to maintain this record.

The President's Page

Gentlemen:

As we approach the end of the year we come also to the end of my term as president. I have enjoyed trying to accomplish something constructive, and feel I have succeeded in a measure. As secretary I shall continue to give time and effort to further the interests of the profession, of our Society, and the individual members whom I am privileged to assist.

I had the opportunity last month to attend a meeting of the American Urological Society in New York City, at which meeting a symposium on anilin tumors of the urinary bladder was presented by four of our own members, Drs. Anderson, Gay, Gehrman, and Washburn. I want to take this means of again congratulating them on the most excellent presentation of their papers and the completeness with which they covered the field. I think our Society is to be congratulated because of them. I was as well impressed with the thoroughness of the way the meeting was conducted. Topic slides had been prepared from all the papers and were shown on the screen while the paper was being presented. It helped very much to understand this most interesting subject.

We have succeeded in helping our members get at least a larger amount of pay for work done, but it is the maximum amount that the State will allow. You will see the complete schedule elsewhere in this issue.

I wish to again thank those who assisted me during my term of office as president. I hope to have the cooperation of all in my duties as secretary.

And now in closing I want to send the Season's Greeting of the Merriest of Christmas times and the Happiest of New Years you and yours have ever enjoyed.

Sincerely,

WILLIAM H. SPEER, M. D.

EDITORIAL

DELAWARE STATE MEDICAL JOURNAL

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All correspondence regarding editorial matters, articles, book reviews, etc., should be addressed to the Editor. All correspondence regarding advertisements, rates, etc., should be addressed to the Business Manager.

Local news of possible interest to the medical profession, notes on removals, changes in address, births, deaths and weddings will be gratefully received.

All advertisements are received subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association.

It is suggested that wherever possible members of the State Society should patronize our advertisers in preference to others as a matter of fair reciprocity.

Subscription price: $2.00 per annum in advance. Single copies, 20 cents. Foreign countries: $2.50 per annum.

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THE NEW LIBRARY

The local need for a medical library has long been felt, both in Wilmington and its vicinity, and it was with this need in mind that a group of doctors organized the Delaware Academy of Medicine in February, 1930, for the purpose of establishing a medical library in this State.

Through kind and interested laymen the Academy was presented with the beautiful colonial building, formerly the old National Bank of Delaware which stood at Sixth and Market Streets and which was reerected at Lovering Avenue, Union Street and Park Drive. The second floor of this building is devoted to library purposes and contains the main library and reading room, a smaller room for Journals, and a committee room.

Many changes have taken place in every phase of living since the time of the dedication of this building as a bank in 1815 when some Philadelphia bankers declined an invitation to be present saying that traveling was too dangerous to venture as far as Wilmington. Many discoveries have been made along the lines of medical knowledge. From ancient times, when it was shrouded in magic and superstition down to modern times, medical science has gradually developed through experimentation and research. Medical literature records that gradual development made through experimentation and research. The knowledge and experience of the past stimulate and inspire the doctor today to further progress and to the discovery of new ways to aid in the eradication of disease and alleviation of suffering.

Every doctor in this state should have access to the leading medical and surgical and special journals of the world, and the most important books. One person can subscribe to only a small proportion of such a large number of professional journals, and it is obvious that the facilities of a library afford a much wider range of reading and investigation. In adjoining states there are excellent medical libraries, some of which had very modest beginnings, no more auspicious than the present modest start in Delaware. The plans for a well-equipped medical library at the Delaware Academy of Medicine are considered a forward step in the activities of the medical and dental professions of this state.

With a nucleus of approximately 2000 volumes on medicine, surgery, dentistry and allied subjects, some having been acquired by purchase and some through private gifts, it is hoped to gradually build up a library that can meet the wants of the man engaged in special investigation and of the members of the medical profession in general.

In building up our collection we are mindful of the interest in all material relating to medical affairs. No doubt there are in Delaware many volumes by early American as well as foreign writers which are interesting as showing the advancement of medicine through the centuries past. Such old books, old medical and

surgical instruments, possibly old portraits, or engravings relating to medicine, files of periodicals to which our early practitioners contributed, old case histories, and old office accounts will increase in interest as the years pass, and we ask the cooperation of the profession of the state in securing for permanent preservation the many items relating to medical past. Anyone knowing of libraries, individual volumes or any of the items mentioned above, available either as gifts or loans are asked to communicate with the library so that arrangements may be made for obtaining them.

Modern scientific works and files of the leading journals, American and foreign, on special as well as general subjects are desired by the Library and anyone contributing them either as loans or gifts has the pleasure of knowing that they are placed where they will be useful to a large group. Through memorials, bequests, and gifts to the endowment fund the goal has been set—the accumulation of a working library, which will be of service to each member of the profession.

A cordial welcome is extended to all who may have use for the facilities of the library. Even if you do not think you have any interest in or need of the library, come in and browse around a bit—something on the shelves and tables will surely catch your fancy.

ANOTHER BIRTHDAY

With the current edition of THE JOURNAL the present editor completes his eighteenth year of service. Many of our older members will recall the first issues, which appeared in 1910, with Dr. Harold L. Springer as editor and Dr. Joseph W. Bastian as business manager. This was a monthly of four to eight pages. In 1914 Dr. Springer was succeeded as editor by the late Dr. Albert Robin, and by this time THE JOURNAL had grown to 16 to 20 pages, but still retained its pamphlet size. In January, 1916, the present editor became the acting editor, assisting Dr. Robin, who wished to be relieved of this task. In April, 1916, Dr. Robin retired from the editorship, and the duty of carrying on Delaware's medical journal fell upon our shoulders, where it has since remained.

Due to the stress of war times THE JOURNAL was published as a quarterly from January, 1918, to December 1922. Following this, the Delaware journal was combined with the Pennsylvania journal and published again as a monthly under the title of the *Atlantic Medical Journal,* with Dr. Frank C. Hammond, of Philadelphia, as editor and the Delaware scribe as assistant editor. The business details were conducted by our Pennsylvania confreres entirely, Dr. Bastian severing his connection with our journal in December, 1922. The hopes of the two states in merging their journals—that the *Atlantic* might become the organ of several nearby states—did not materialize, and the arrangement was cancelled with the issue of September, 1928, each state having decided to resume publication of its own journal under the original titles.

Thus a new series of the DELAWARE STATE MEDICAL JOURNAL began in January, 1929, with the old Delaware editor back on the job, assisted by Doctors W. O. LaMotte and M. A. Tarumianz, who has also served as business manager. The new journal conforms in style and format to the other state journals: we are trying to make it compare favorably with them in interest and value. We can succeed in this attempt only if all our members will continue their sympathetic support.

EDITORIAL NOTES

The F. E. R. A. plan for Delaware appears in this issue, in sufficient clarity to be readily understood by all our members. This issue of THE JOURNAL should be preserved for future reference, as a re-reading of the Federal and State documents will answer most of the questions that may arise and thus eliminate at the source much work that otherwise may devolve, sometimes unnecessarily, upon the committees on medical economics.

It is now up to every physician in the state to play the game understandingly and sympathetically with the authorities, for both the commission and the profession have a common aim—good medical care for the indigents who are "on the Relief."

The Delaware Academy of Medicine announces a series of monthly clinical pathological conferences, to be held on the third Friday at 8.30 P. M. They will be conducted by Dr. Pfeiffer, surgeon; Dr. Robinson, pathologist

and Dr. Miller, radiologist, all of Philadelphia.

The sole credit for this series belongs to Dr. Raymond B. Moore, who started them at his residence last month, when the thirty-five physicians who were present declared the session one of the most informative and stimulating they had ever attended anywhere. So instantaneous was the success of Dr. Moore's venture that the officers of the Academy offered their building that the anticipated larger attendance might be accommodated. The physician who does not attend this new series of educational conferences is going to miss something good. The entire profession is invited.

The Johns Hopkins Hospital is remodelling one of their old buildings into two wards, one for men and one for women, which are to be divided into private cubicles that shall be priced so moderately that they will be within the reach of many who are now forced to seek semi-private or pay ward accommodations. The new wards are to be memorials to the late Dr. William S. Thayer, former professor of medicine, who always felt that the private facilities of our great metropolitan hospitals were too costly for the great middle class of people. More of our big city hospitals should follow this example.

Merry Christmas, doctor dear!
May the Yuletide bring you cheer.
Broke and broken though you be,
Face these rough times manfully;
Times won't always be like this—
'34 may bring you bliss.
Folks will some day say to thee:
"Here's your cash." So mote it be!

WOMAN'S AUXILIARY

The Woman's Auxiliary of the Medical Society of Delaware will have as president for the coming year Mrs. Joseph McDaniel, of Dover. New officers were elected at the meeting on December 12, 1933, at the Wayside Inn, Smyrna. Mrs. Richard C. Beebe, of Lewes, elected to this office at the last meeting, was unable to serve.

Mrs. McDaniel succeeds Mrs. Robert W. Tomlinson, who was this year elected president of the national Auxiliary and will assume her duties at the convention to be held in Cleveland in June, in conjunction with the American Medical Association.

Other officers named at yesterday's meeting were: Mrs. Gerald Beatty, Brandywine Sanatorium, secretary; Mrs. C. E. Wagner, Wilmington, treasurer; Mrs. Ira Burns, Wilmington, vice-president for New Castle County; Mrs. W. C. Deakyne, Smyrna, vice-president for Kent County, and Mrs. E. L. Stambaugh, Lewes, vice-president for Sussex County. The new officers will assume their duties January 1.

Mrs. Frank G. Tallman addressed the meeting, speaking particularly of the work of the State Board of Health, and the home safety division of the Delaware Safety Council.

OBITUARY

DR. CECIL DEJ. HARBORDT

Dr. Cecil deJoline Harbordt, age 47, of Dover, died in Delaware Hospital from a liver complication. He had been in the hospital since October 15.

Dr. Harbordt was born December 3, 1885, in Brooklyn, N. Y., the son of Emile Charles and Clara A. Harbordt. Attending the public schools of that city, he finished his academic education by graduating from New York University in 1901 with the degree of bachelor of arts. He graduated from the Medical School of the University of Maryland, Baltimore, in 1905, with the degree of Doctor of Medicine,

Following an internship at the Franklin Square Hospital, Baltimore, he came to Wilmington, where for six months he maintained offices. In 1906 he moved to Dover where for eighteen months, he was assistant to Dr. J. H. Wilson. Later he opened up an office of his own in Dover.

During the war he served in the Naval Hospital in Philadelphia. Following his war service, he returned to Dover and resumed his practice. In 1918 he married Miss Mollie M. Hirons. They had no children.

Dr. Harbordt was staff surgeon for the Kent General Hospital at Dover and lecturer to the student nurses of the Milford Hospital.

Dr. Harbordt was a member of the Independent Order of Odd Fellows, Patriotic Sons of America, Ancient Order of United Workmen, Mapledale Country Club, Theta Kappa Psi Fraternity and the State, County and American Medical Associations.

MISCELLANEOUS

Re: Amoebic Dysentery

So that you may be informed as to the present status of the amebiasis situation as it confronts us here in Chicago, I am giving you the following figures for your information:

To date there have been reported 419 cases, involving 138 cities, with a total of 26 deaths. Apparently these cases originated in Chicago. We have also discovered 384 carriers.

May I also list chronologically for you, the various steps in relation to this outbreak and its control:

For some years, approximately two cases of amoebic dysentery have been reported each month to the Board of Health. On August 15, a report of two cases in hospitals in Chicago came to our attention, and investigation revealed that both patients had eaten at one hotel in this city. An immediate examination was made of all food handlers in this hostelry. These examinations, completed by September 1, indicated sixteen persons with active diarrhea whose stools contained endameba histolytica, and eleven carriers of the organism.

Since available statistics indicate that approximately 5 to 10 per cent of the entire population are infested, this observation did not seem to be reason for serious concern. This was particularly the case since an outbreak in another Chicago hotel in 1927 had apparently been fully controlled by the establishment of certain stringent sanitary precautions. These same precautions that controlled the 1927 outbreak, were established in the hotel concerned in the present outbreak and are still in force. In the meantime, the situation was continuously studied.

As further clinical cases were not reported from either the hotel concerned or the city at large, it did not seem necessary at that time to make general announcement. Nevertheless a preliminary report was read before the American Public Health Association meeting in Indianapolis on October 9 and released to the press which, unfortunately, did not apparently consider the item of enough significance to give it widespread circulation.

The incubation period of amoebic dysentery may be as long as 94 days. Therefore, about the middle of October, reports began to come in, indicating the presence of some cases outside Chicago among persons who had stopped at the hotel concerned during the previous four months. Steps were taken immediately to re-examine every food handler as well as the non-food handlers. Moreover, questionnaires were sent to all persons who had registered at the hotel during June, July, and August. As these questionnaires were returned, the Board of Health of the City of Chicago used the long distance telephone and telegrams to apprise both physicians and patients of the necessity for a study of every case of diarrhea for possible amebiasis.

By November 5, although only one-fifth of the questionnaires had been returned, enough well authenticated data were at hand to justify us in beginning to assemble them for publication. Full reports were made and published in The Journal of the American Medical Association, the information being released simultaneously to newspapers and news periodicals on November 14.

From the first day that we were notified of the existence of a case of amoebic dysentery, and every day thereafter, as soon as a case was reported to us, we immediately notified the State Director of Health at Springfield, Illinois, and he in turn made a report of those cases to the United States Public Health Service by telegraph each Monday. After thoroughly investigating the situation here in Chicago, Dr. Roscoe R. Spencer, of the United States Public Health Service, issued the following statement:

"Everything humanly possible has been done to control the outbreak. There is certainly no need for any general alarm. Dr. Bundesen and the Board of Health are to be congratulated on the promptness, aggressiveness and thoroughness with which the situation has been handled."

I shall appreciate it if you will advise me of any cases with a possible Chicago origin that come to your attention, and I shall keep you informed, from time to time, as to what is occurring.

With kind personal regards, I am

Very truly yours,

HERMAN N. BUNDESEN,

President, Board of Health, Chicago

Dec. 2, 1933.

New Product for Diphtheria Immunization

The Squibb Laboratories announce the availability of refined diphtheria toxoid, alum precipitated, with the featured advantage that one injection is sufficient for the immunization of the majority of children against diphtheria. The efficacy of the preparation in immunizing against diphtheria is believed to be due to the fact that the alum precipitated toxin, since it is relatively insoluble, is more slowly absorbed and remains in the body sufficiently long to produce adequately protective amounts of antitoxin.

One injection of alum precipitated toxoid is reported to be as effective as two or three injections of ordinary unprecipitated toxoid, and is also said to produce a greater number of negative Schick tests, that is, a higher percentage of immune individuals. These features make alum precipitated toxoid of particular value in public health work, for two or three times as many persons may be immunized with no more effort nor time on the part of the public health worker. It also makes it easier for the family physician to follow the advocated procedure of immunizing every infant, at whose birth he has officiated at 6 months of age.

Squibb Refined Diphtheria Toxoid Alum Precipitated is prepared according to the method reported by the Alabama Board of Health for a single-dose treatment. It is marketed in 0.5 cc. vials for immunization of one person, and in 5 cc. vials containing sufficient material for the immunization of ten individuals.

The Threat of Amebiasis in the Food Handler

According to FRED O. TONNEY, GERALD L. HOEFT and BERTHA KAPLAN SPECTOR, Chicago (*Journal A. M. A.*, Nov. 18, 1933), sixteen clinical cases and eleven carriers of the encysted Endamoeba histolytica were found among 364 food handlers examined up to Sept. 1, 1933, in a large hostelry. Five clinical cases had also been reported in other employes not engaged in food handling, and eleven clinical cases among the guests and diners. The effort to control the outbreak consisted of exclusion of the infested food handlers from the kitchens and rigid application of appropriate sanitary measures. The indications point to an old carrier, previously detected in 1927, as the most plausible primary source of the outbreak. Proof of this, however, is necessarily lacking and there were several other possibilities of causative agents among the food handling personnel. The danger of recurrence of the infestation, even after most thorough and competent treatment, is emphasized in the case of the employe mentioned, who was associated with a previous outbreak in 1927. The authors recommend that food handlers who are known to have suffered from amebiasis be required to submit specimens of excreta every six months for examination by an approved public health laboratory, as long as they continue to work as food handlers. The incident reported is a striking illustration of the constant need of well equipped research laboratories in modern public health organizations—laboratories liberally manned by a well trained technical personnel, which can be drafted at a moment's notice for such emergencies as this and which in the meantime can be kept permanently and profitably occupied with a study of improved methods of conserving human life and health.

Extent of Retention of Ingested Aluminum

According to the experiments of E. W. SCHWARTZE, GERALD J. COX, RICHARD B. UNANGST, F. J. MURPHY and HELEN B. WIGMAN, with the assistance of W. H. BRADLEY and R. C. UHLIG, Pittsburgh (*Journal* A. M. A., Nov. 25, 1933), the aluminum content of fresh tissues of guinea-pigs receiving no added aluminum is about 0.4 part per million or less. The carcasses of growing guinea-pigs on a diet containing no added aluminum have a higher content of aluminum than those of the adult animals. The feeding of large amounts of soluble aluminum salts produces a barely detectable deposition of aluminum in the soft tissues (less than 0.5 part per million) and somewhat larger amounts (from 0.5 to 1 part per million) in carcasses. No systemic pharmacologic effects can be ascribed directly to absorbed aluminum. Aluminum does not appear to be cumulative in the tissues. No harmful effects can be expected from soluble aluminum occurring naturally in foods or introduced by utensils into a diet of normal phosphorus content.

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OBITUARY

Dr. William H. Hancker, former Superintendent of Delaware State Hospital, died December 29th at 9:30 A. M., in his apartment in the Delaware State Hospital. Funeral services will be held at the home of Dr. M. A. Tarumianz, Farnhurst, Delaware, on Tuesday, January 2nd.